WESTERN NEW YORK
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February 7, 2018

Chairman Ajit Pai
Commissioner Mignon Clyburn
Commissioner Michael O'Rielly
Commissioner Brendan Carr
Commissioner Jessica Rosenworcel

Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Dear Chairman Pai and FCC Commissioners:

Western New York Rural Area Health Center, Inc., (R-AHEC), a 501 (c)(3) not-for-profit organization located in Warsaw, New York, administers the Western New York Rural Broadband Healthcare Network (WNYRBHN), a consortium leader for the Healthcare Connect Fund (HCF) program. The WNYRBHN is a consortium of over 130 health care providers (HCPs) mainly in rural and medically underserved areas of upstate New York who rely on the HCF for broadband support.

R-AHEC is pleased that the FCC has released this Notice of Proposed Rule Making (NPRM), and R-AHEC provides the following comments in response to the NPRM:

15. We seek comment on increasing the cap for the RHC.

We are in favor of increasing the cap for the RHC program. The GDP-CPI adjustment that the E-rate Program uses would be acceptable as a minimum, but be aware that the pace of technology adoption increases exponentially. The $400 million annual cap was implemented over 20 years ago and has never been adjusted for inflation; furthermore, it was based on grossly incorrect estimates of the number of qualifying rural health care providers in the nation.

17. We also seek comment on whether we should roll over unused funds committed in one funding year into a subsequent funding year.

We are in favor of rolling over a reasonable portion of unused funds to current years. A certain portion should be reserved for open appeals but the RHC program should mirror the E-rate program protocol in rolling all unused funds forward inasmuch as possible.

18. We seek comment on whether we should consider changes in how we prioritize the funding of eligible RHC Program requests.

The particular mechanics of fund distribution prioritization once a cap is reached should be relatively transparent and forecastable, and facilitate rapid decision-making by USAC, so that reasonable IT planning and budgeting can be employed by health-care facilities.

We think that the urban/rural divide is decreasing as partnerships and consolidations increase. The HCF has facilitated these partnerships to a degree and improved rural health care as a result of this increased partnership. Further, if a circuit runs from a rural facility to an urban facility, is this circuit rural or urban? Strictly limiting funding for urban facilities would be a disservice to numerous rural facilities that have partnered with the urbans.

The fact of the matter is the program has favorably impacted the quality of rural health care. If the program is overly restrictive in rural versus urban subsidization, who will rural facilities connect to as the partnerships and consolidations increase?

19. By adopting a prioritization plan, would the RHC Program disbursements be more specific and predictable when demand exceeds the cap?

If, in fact, proration is required, the most expeditious and "fairest" method seems to be simple proration as was done in the last filing window. To add layers of complexity onto an already burdened USAC staff would be unwise.

25. We also must explore how to handle requests for funding from consortia under the HCF Program.

Requests from consortia should either be handled the same or with greater incentive/higher priority—but certainly not lower priority—than individual requests. Consortia consist of the same types of health care providers that are found outside a consortium, and in many cases consortium members have an even greater need for the RHCP. This is why they have joined a consortium; they do not have the administrative resources to undertake the RHCP on their own. If consortia are de-incentivized, it will hurt the same kind of small rural providers that would be hurt by de-incentivizing individual applications.

Furthermore, because consortium bidding is more lucrative to service providers, this drives higher competition and lower pricing. Why would we deliberately make competitive pricing more difficult to obtain? Why would we deliberately make it less appealing for rural health care providers to join a network which provides better pricing and more connectivity, all the while handling the entire administrative burden so that it is not passed on to the HCPs? If anything, consortia should be encouraged.

29. **Should we prioritize one RHC Program over the other? Currently, our rules provide for equal treatment of the two programs when the cap is exceeded, for purposes of prorating support. We also note that section 254(h)(2)(A) requires the Commission to establish competitively neutral rules for healthcare provider access to advanced telecommunications and information services to the extent "economically reasonable."**

a. Rapid develop of telemedicine due to limited access to specialists in rural areas will drive the relative increased priority of broadband versus telecommunications.

b. Most if not all of the telecommunications being funded by the Telecom program can be provided over broadband in an equivalent manner (VoIP, UCaaS, etc). In geographical areas where broadband limitations favor the Telecom program, shouldn't it be a goal to neutralize these limitations and further the capabilities of broadband? This is only possible if the HCF program is given priority.

c. Due to the ways that support is calculated, there is far more potential for waste and abuse under the Telecom program. We have seen this in Alaska, a remote, low-population state which has obtained 30% of the annual funding for both programs through the Telecom program alone with 99% discount rates.

Therefore, if the cap is exceeded and one program must be prioritized over another, funding should shift toward the Healthcare Connect Fund.

31. We also seek comment on whether we should prioritize funding to areas with health care professional shortages.

We think that using The Health Resources and Services Administration (HRSA) identification of Health Professional Shortage Areas (HPSA, Medically Underserved Areas and Medically Underserved Populations (MUA/P), and state identified rural health care clinics that do not otherwise qualify for HPSA or MUA/P designation to prioritize funding may not fully optimize regional health care, since many of these areas are treated by larger, regional facilities.

In closing, we agree that measures should be taken to reduce and eliminate waste, fraud, and abuse, and we believe that the annual funding cap should be increased through logical reasoning in order to meet modern needs.

Furthermore, we believe it is imperative that the needs of consortia are not minimized in an attempt to improve the RHCP. Consortia play a key role in providing administrative assistance to the small, rural health care providers that need the RHCP the most. Making consortia a lower priority does not equate to making small rural health care providers a higher priority; in fact, it does just the opposite. The majority of the members that make up a consortium consist of the very health care providers that the RHCP was designed for. This is why they joined a consortium—they do not have the resources to tackle the nuances of the Program on their own.

Raising the annual funding cap and eliminating waste, fraud, and abuse are crucial steps to improve the sustainability of the RHCP. However, diminishing the capabilities of consortia will not help rural health care providers; it will only harm them, because they are what makes up the very essence of a consortium.

Thank you for your time and consideration. We can be reached for questions at the phone number or email address below.

Sincerely,

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